Memorandum

Feb. 3, 2009

To: Health Care Advisory Council
From: Rob Wittman

Thank you for agreeing to serve on this important advisory committee. America's health care system is in need of fundamental reform. We simply must make health care more affordable, enhance access for all Americans, ensure that patients are getting the care they need, and guarantee that doctors and patients, not insurance companies, are making important health care decisions.

I am committed to finding solutions that achieve health care reform consistent with these goals.

While I have legislative reform ideas that I think merit serious consideration, it is critically important that I hear from you. I want an open dialogue with the people of Virginia's 1st Congressional district, including doctors, nurses, patients, and other health care professionals who have a daily, up-close experience with the problems facing America's health care system. Working together, I know we can find innovative solutions that put us back on the right track.

The challenge before us is a difficult one. Today, approximately 46 million Americans (nearly 16% of the U.S. population) lack health insurance. Since 1999, health care insurance premiums have more than doubled for most Americans. Meanwhile, workers' wages have not kept pace.

Virginians are not immune to the nationwide trend in health care. For the last several years health care premiums in Virginia have increased at approximately ten percent a year. And, today, more than 1.1 million Virginians are uninsured. From the hourly worker in Newport News, Virginia, who must somehow find room in his or her budget to pay for health insurance to the small business owner in Fredericksburg, Virginia, who voluntarily chooses to provide health insurance as a benefit to his or her employees but with the slowing economy is finding it incredibly difficult to absorb increased health insurance costs, Virginians are struggling to find affordable health care.

Given the rising trend in health care costs and the struggling U.S. economy, the simple fact is that the number of uninsured will continue to increase unless we confront the issue now, head-on, and in a bipartisan fashion.

Below, please find a discussion draft of possible health care reforms. I present them to you in an effort to start a serious dialogue about finding solutions to a complex issue. I know we can improve the nation's health care system, reduce the number of uninsured individuals and families, and decrease the costs of health care.

I appreciate your taking the time to review these broad legislative ideas. I look forward to your thoughts and look forward to working with you in crafting solutions.

I. **Health Information Technology**

- Despite the fact that most segments of our economy have harnessed the benefits of new technologies, the fact is that only 15-20% of physicians in the United States have adopted the use of electronic medical records. Most physicians still keep paper medical records.

- Widespread use of electronic medical records can achieve health care savings by improving health care efficiency and safety.

    - With paper records, a doctor may not have access to a patient's complete medical history in light of the fact that patients see a number of different doctors, including primary care doctors and specialists. In addition, patients with medical emergencies might be seen by an emergency room doctor that has no access to a patient's important medical information, such as allergies or current prescriptions.

    - Sometimes handwritten prescriptions can be tough to read and are misunderstood by pharmacists.

- According to a Congressional Committee, "a major barrier to widespread adoption of health information technology in the U.S. health care system is the high cost of such technology." In addition to acquisition costs, there are typically system maintenance, management, and personnel costs associated with the purchase and use of such technology.

- The federal government should provide tax incentives and/or grants to doctors, hospitals and others to help facilitate the adoption of interoperable health information technology.

- The American Recovery and Reinvestment Act of 2009, (the stimulus bill) contains $20 billion to help promote the nationwide exchange of health information technology. Among other things, the legislation provides financial incentives through increased Medicare payments to encourage doctors and hospitals to use certified health information technology in a meaningful way.

II. Community Health Centers & Free Clinics

A. Community Health Centers

- Community Health Centers (CHCs) are non-profit health clinics located in medically underserved areas that provide comprehensive primary health care services to anyone seeking care. From doctor care, to laboratory services and from immunizations to preventative care, CHCs serve more than 17 million uninsured patients at approximately 7,000 sites nationwide – all on sliding scale fee basis based on ability to pay.

- The federal government supports community health centers (also known as federally qualified health centers) by appropriating over $2 billion a year. These funds comprise approximately 20% of the budget of the average federally qualified health center. CHCs receive the rest of their funding through local fundraising, through insurance payments, particularly from Medicare and Medicaid, and through patient co-pays.

- In my view, CHCs are wise investments of federal dollars. By providing high quality health care, including preventative care, to people who otherwise have a hard time accessing such care, CHCs help address health care problems early on, thus preventing more costly visits to the emergency room. In recognition of the critical role that CHCs play, in 2008, Congress overwhelmingly passed H.R. 1343, with my support. Among other things, this legislation authorized an increase in CHC funding by more than $1.3 billion over the next five years.

- We should examine ways to promote the expansion of Community of Health Centers and ways to help them operate even more effectively.

B. Free Health Clinics

- Free health clinics are private, non-profit organizations that provide quality health care at little or no charge to low-income, uninsured people. Most of the funding for free clinics comes through charitable donations, although the Commonwealth of Virginia also provides some funding for clinics in Virginia. Volunteer physicians and other health care professionals play a key role.

- Like CHCs, free health clinics can and should play a meaningful role in health care reform. By providing primary and preventative care to people who otherwise would not have access to care, free health clinics help keep people out of more costly health care settings, such as hospitals and emergency rooms. Many such clinics operate at or near capacity and some have to turn away uninsured patients in need. Finding ways to help free health clinics operate even more effectively in serving the community is important.

III. Medical Liability Reform

- While true victims of medical malpractice deserve to be fairly compensated for their injuries, the fact is that patient access to medical care is threatened by frivolous lawsuits and runaway jury awards.

- Liability concerns can force doctors to leave the practice of medicine and make changes to the types of services they offer in their practice.

- The American Medical Association estimates that medical "liability pressure increases health system costs by between $84 and $151 billion per year."

- Currently, medical liability laws differ from state to state. A fair, balanced, nationwide cap would lower health care costs and enhance access to health care services.

IV. Health Care Reform for Small Businesses

- Small businesses are the engine of our economy. According to the U.S. Small Business Administration, since the mid 1990s, small businesses have created 60-80 percent of all new jobs in America. As a result, today, approximately half of all private sector jobs come from small businesses.

- No business in America is required by law to offer health insurance for their employees, but for those businesses that do, it is a major cost of doing business. With health care premiums increasing, and with the economy struggling, small businesses need relief. We must find a way to make it affordable for them to offer health insurance benefits to their employees.

A. Small Business Group Health Plans

- Health care premiums for small businesses are nearly 18 percent higher than those of larger businesses. This is due, in part, to the fact that small businesses, when negotiating rates with insurance companies, don't have the same purchasing power as large companies. It is also due, in part, to the fact that because a small business insurance plan covers a small universe of people, rates are more susceptible to substantially increasing should even a single employee have a serious medical condition.

- Allowing small businesses to pool together with similar businesses all over the country to purchase a group health insurance plan will make health insurance more affordable by: (a) spreading risk among a much larger group; and (b) by enhancing the negotiating power of small businesses with insurance companies.

B. An Examination of Health Insurance Mandates

- Many health insurance plans are regulated by the state, not federal law. Each state has its own set of laws mandating certain benefits that must be included in any health insurance plan offered in that state. Such mandates have increased exponentially over time. According to the Council for Affordable Health Insurance (CAHI), today, more than 1,840 health care insurance mandates exist nationwide where as only a handful existed in the 1960s. CAHI estimates that such mandates can boost the cost of an insurance policy between 20 and 45 percent.

- We should examine whether it makes sense to allow small businesses that have joined together across state lines to offer a group health insurance plan to their employees to choose which state's law will govern the plan. Small businesses that pool together for such purposes should be able to abide by one set of state laws, rather than be governed by each state's law in which the group is offering insurance.

- Small businesses shouldn't be faced with the choice of offering their employees a "Cadillac health care plan" or no health care plan. There has to be some middle ground for those small businesses struggling to provide this important benefit.

V. Increased Funding for Medical Research

- The National Institutes of Health (NIH) is the world's premier medical research agency, and it plays an important role in improving the health of the nation. Federal investments in NIH funding help spur medical breakthroughs, which enable Americans to lead longer, healthier lives.

- From fiscal year 1998 to fiscal year 2003, federal funding for the NIH budget doubled from approximately $13.5 billion to $27 billion per year. Since then, however, funding has not kept up with inflation, and according to the Congressional Research Service, the NIH, in inflation adjusted terms, has seen an estimated 11% decrease in funding since fiscal year 2003.

- Given the budget situation in Washington today, some will undoubtedly be skeptical of adding additional funds to any government program, including research funding at the NIH. In my view, additional investments in the NIH will reduce health care costs over the long run as we achieve more and more medical breakthroughs which enable Americans to live healthier lives.

VI. Enhanced Transparency in Health Care

- Many Americans who have health care insurance are fully aware of the premiums they pay each pay period for that insurance; however, many of us are by and large in the dark when it comes to knowing the full cost of a doctor's visit, an x-ray, an electrocardiogram or any other procedure.

- In other sectors of our economy, consumers have access to pricing information. For example, if one were searching for mortgage rates, he or she would be able to compare the rates and fees of various lenders. For some reason, access to pricing information in health care is not easily obtainable.

- Transparency in health care pricing and in health care quality is important so consumers can make informed decisions about doctors, hospitals, and medical care. If one were to assume that a consumer, empowered with such knowledge, would actively seek out the highest quality of care at the most affordable cost, then a consumer could actually drive down health care costs and enhance health care quality.

- In recent years, there have been efforts on a federal level to provide incentives to consumers to learn more about health care costs. In 2003, access to health savings accounts (HSA) became more widespread due to Congressional action, and today it is estimated that 6.1 million Americans have a health savings account, although this represents only a fraction of all insurance policies. An HSA is a tax-advantaged medical savings account that is used to pay for medical costs in conjunction with a high deductible health insurance plan. Any monies contributed to an HSA are not subject to federal income tax at the time of deposit, and funds may be withdrawn from the account for medical expenses without any federal tax liability. Insurance coverage only kicks in once the consumer has met a fairly high yearly deductible. Until that deductible is met, consumers pay for health care out of their HSAs.

- Whether a consumer is a participant in an HSA, or a purchaser of a more traditional insurance policy, he or she, should have access to health care quality and health care pricing information.

VII. Putting Doctors Back in Control of Health Care Decisions

- In today's managed care environment, even if a particular procedure is a covered benefit under an insurance policy, the health insurance plan could still deny the benefit in a particular case if it found that such a procedure was not medically necessary. All too often, when an insurance company denies coverage, these denial decisions are made contrary to the patients' own doctor who believes the procedure is medically necessary.

- The good news is that 44 states currently have laws that allow patients to appeal an adverse health insurance coverage decision through an external review board.

- The challenge, however, is whether these state laws adequately put health care decisions back in the hands of doctors. A review of the facts shows:

    - Approximately 47% of insured workers are enrolled in self-insured employer health plans which are governed by federal law and not state law. No federal statute requires self-insured plans to have an external review board made up of medical experts to review adverse health care coverage decisions. Thus, nearly half of all insured employees do not have statutory access to an external review.

    - For those patients who do have a statutory right to an external review there are potential barriers that could, inadvertently, discourage the use of the review procedure. For example, some states require the patient to pay fees to apply for an external review. Most states do not require that denial notices inform consumers of their appeals rights.

- It is important to examine whether state and federal laws adequately ensure that patients and their doctors have a right to appeal an adverse health care decision to an independent external review board comprised of medical experts in the appropriate medical field.

VIII. Co-pay Relief Programs

- Co-Pay relief programs provide assistance to underinsured Americans with chronic illnesses to help assist them in obtaining their medications.

- At present, there are approximately 25 million underinsured Americans. Those living with chronic illnesses such as diabetes, Parkinson's disease, multiple sclerosis, or arthritis must not only fight their illness, they often struggle to find a way to satisfy their required co-pays in order to obtain the very prescription drugs that help them manage their illness.

- These pharmaceuticals might cost over a thousand dollars a month for a single medication, and with co-pays ranging from the typical 25% Medicare Part D co-pay to even higher, these prescription drugs – which are essential to chronic illness disease management - can quickly become unaffordable, particularly for people living on fixed incomes.

- In 2004, the Patient Advocate Foundation – a nonprofit organization in Newport News, Virginia, successfully launched its co-pay relief program, and since then it has provided co-payment assistance to more than 21,000 people living with chronic illnesses who are in need. Still, due to a lack of funding,

Patient Advocate Foundation and other nonprofits can only do so much, and they routinely have to turn people away from their co-pay relief program.

- Ensuring that people with chronic illnesses have access to critical, innovative prescription drugs that help manage their disease will help lower health care costs. These medications can help prevent flare-ups of many of these illnesses and keep people working rather than sending them to the hospital.

- We should examine whether the federal government should partner with nonprofit organizations to expand the reach of co-pay relief programs.